



Disability Rights Education & Defense Fund

---

# **Promoting Physical and Programmatic Accessibility in Managed LTSS Programs**

**Community Living Policy Center Webinar**

**Mary Lou Breslin - February 2019**

3075 Adeline Street, Suite 210 • Berkeley, CA 94703 • 510.644.2555 • 510.841.8645 fax

[www.dredf.org](http://www.dredf.org)

# Topics

- Disability health and health care disparities
- Physical and programmatic access
- Federal actions
- Promising practices

# Health Disparities

# HHS – Advisory Committee on Minority Health – July 2011

- By every measure, persons with disabilities disproportionately and inequitably experience morbidity and mortality associated with unmet health care needs in every sphere. Minorities with disabilities are doubly burdened by their minority status.
- Set the stage for recognizing disability as a bona fide disparities population

# Disability, Health and Health Care Disparities

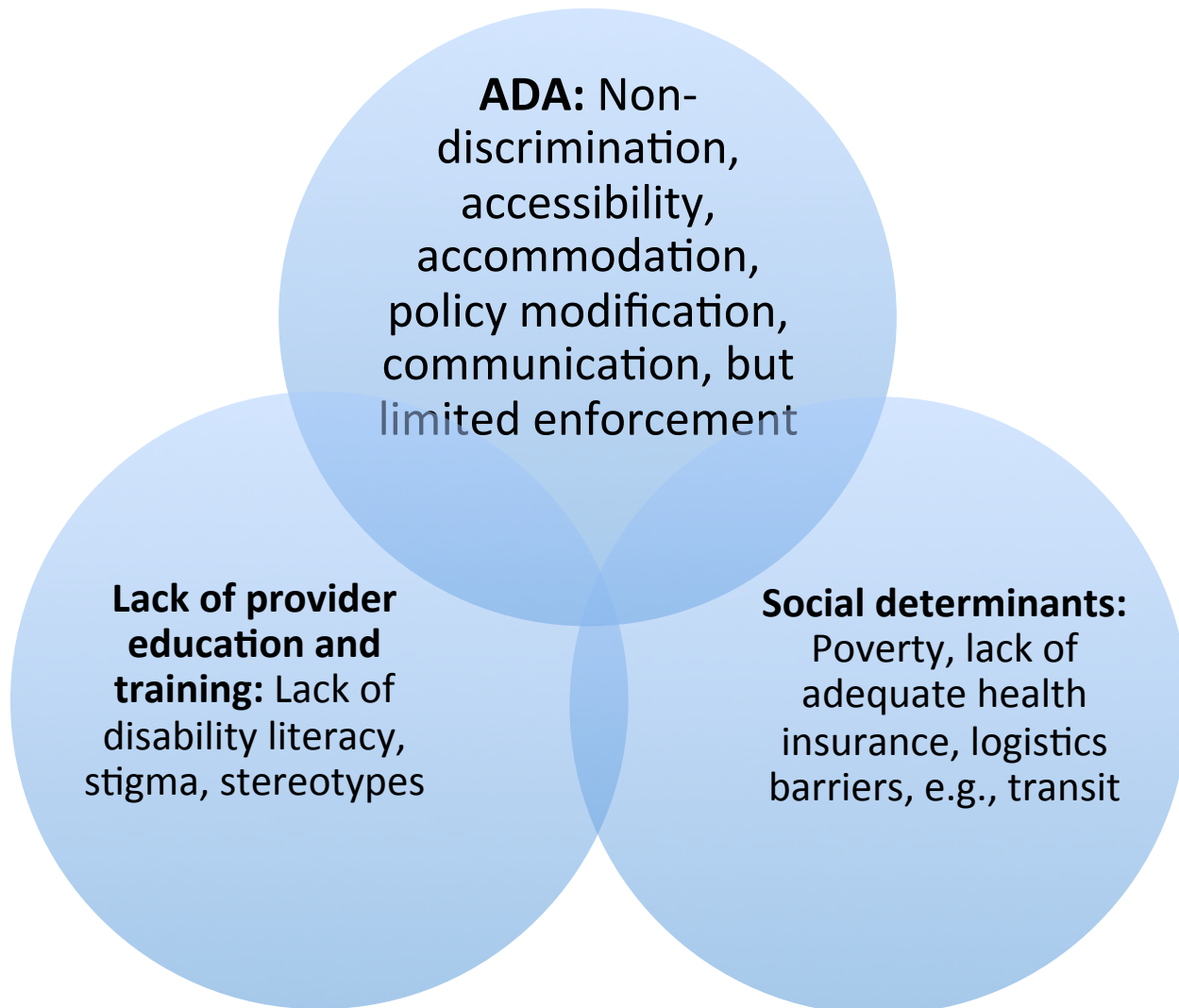
## Healthy People 2020

- People with disabilities are more likely to:
  - Experience difficulties or delays in getting the health care they need
  - Not have had an annual dental visit
  - Not have had a mammogram in the past 2 years
  - Not have had a Pap test within the past 3 years

# Disability, Health and Health Care Disparities

- Women with disabilities have higher death rates from breast cancer<sup>\*</sup>
- Three out of five people with serious mental illness die 25 years earlier than other individuals, from preventable, co-occurring chronic disease<sup>#</sup>
- Disabled people on Medicare die from lung cancer at higher rates<sup>^</sup>

# Why Disparities? Complex Interaction of Factors that Influence Health Status and Health Outcomes for Disabled People



# **Physical and Programmatic Access**

# What is Physical Access?

- Practically speaking, physical access means:
  - If parking is provided, wheelchair accessible parking should be available
  - A level entrance into the facility
  - An accessible path within the facility
  - An elevator if offices and services are provided above the first floor
  - Wheelchair accessible restroom
  - Signage for accessibility features
  - Tactile signage

# What is Programmatic Access\*

- Programmatic access means that the policies and procedures that are part of the delivery of healthcare do not hinder the ability of people with disabilities to receive the same quality of care as other persons
- Where usual healthcare practice may impose barriers, modifications in policy or procedure may be necessary to assure access

# Policies and Procedures Needed for Programmatic Access\*

- Methods of effectively communicating individual medical information and general health information with patients
- Appointment scheduling procedures and time slots
- Patient treatment by the medical staff
- Awareness of and methods for selecting and purchasing accessible equipment

# Policies and Procedures Needed for Programmatic Access\*

- Staff training and knowledge (e.g., for operation of accessible equipment, assistance with transfer and dressing, conduct of the exam)
- Standards for referral for tests or other treatment
- System-wide coordination and flexibility to enable access
- Disability cultural awareness

\*Nancy R. Mudrick, M.S.W., Ph.D. & Silvia Yee, Esq., "Defining Programmatic Access to Healthcare or People with Disabilities," Disability Rights Education and Defense Fund (DREDF), Berkeley, California, 2007, updated 2014.

# Federal Actions

# Federal Actions

- *CMS Equity Plan for Improving Quality in Medicare - Sept 2015*
  - Six priority areas includes:
    - Increased Physical Accessibility of Health Care Facilities
- 2016 Medicaid Managed Care final rule
  - Accessibility info. in provider directories; network adequacy standards; compliance with contract access, equipment requirements

# Federal Actions

- CMS Brief: *Increasing the Physical Accessibility of Health Care Facilities* – May 2017
- ACA established pathways to test new clinical and LTSS models such as the Medicare-Medicaid financial alignment/duals demonstrations
  - (As of 2017, 14 demonstrations operating in 13 states)

# Promising Practices

# Managed LTSS Contracts

- DREDF/CLPC reviewed nine states' managed LTSS contracts for physical and programmatic access language
  - Six Medicare/Medicaid duals demonstration contracts for:
    - Virginia, Illinois, Massachusetts, Michigan, New York, and South Carolina
    - (Virginia has since concluded its demonstration)
  - Three other Medicaid managed LTSS contracts for:
    - Minnesota, New Mexico, and New Jersey

# 10 Key Contract Elements

1. ADA/section 504 policies and procedures
2. Provisions for disability awareness and cultural competency
3. Provisions for reasonable accommodation, policy modification, and auxiliary aids and services
4. Responsible person
5. Spell out required actions for health plan, itself

# 10 Key Contract Elements

6. On-site accessibility review
7. Required assessment of capacity to provide accommodations such as ASL, alternative formats, extend exam time
8. Use of specific accessibility survey tool
9. Compliance plan
10. Access information in provider directory

# Key Elements in Duals Demonstration Contracts

- Virginia, Illinois and Massachusetts include 10 elements
- South Carolina and Michigan include nine elements
- New York includes eight elements
  - does not require uniform survey instrument
  - self-assessment/attestations okay

# Key Elements in Non-Duals Demonstration Contracts

- New Jersey - most of 10 elements required
- New Mexico includes only six elements
  - Culturally and linguistically sensitive
  - Almost no physical or programmatic access provisions
- Minnesota – only two limited elements
  - Materials in accessible formats
    - Also, accessible information must be readily available
  - Adequate number of providers who serve ASL speakers

# Why is This Important?

- Among the six duals contracts-
  - A ground shift in federal expectations and requirements for physical and programmatic accessibility that apply to:
    - managed-care organizations, themselves, and
    - the providers with whom they contract
  - Contracts contain uniform provisions that reflect readiness review process
  - Language an important statement of principles that are built on the social model of disability

# Challenges

- Contracts are not self-executing
  - Meaningful implementation involves data collection, monitoring, reporting
- Information on physical and programmatic accessibility of healthcare facilities and services is limited state by state
- No national-level data

# Promising Practices

- Emerging community partnerships illustrate possible paths forward
- Two examples:
  - California facility site review – all Medicaid managed care organizations must conduct on-site primary care office reviews using standardized survey
  - Centene health plan partners with NCIL

# California Facility Site Review

- Medicaid managed care organizations conduct on-site survey of all network primary care offices using 86-item instrument
- DREDF/Syracuse University—summary of FSR data from 5 MCOs—2010 and 2017
- Accessible exam tables and weight scales
  - 2010 data: 2389 primary care provider offices
    - 8.4% -- height-adjustable exam table
    - 3.6% -- accessible weight scale
  - 2017 data: 3993 primary care provider offices
    - 19.1% – height adjustable exam table
    - 10.9% – accessible weight scale

# California Facility Site Review

- Physical access
  - Offices are mostly accessible, with small additional improvement over time
  - Increase in accessible exam equipment and accessible toilet rooms
  - Survey provides a meaningful indication of office accessibility, with a replicable methodology

# California Facility Site Review

- Concerns
  - Offices with accessible exam tables and weight scales remains very low
  - Other equipment to assist with patients with mobility limitations is extremely scarce
  - Implementation of accessible features requires proactive effort, not simply an audit

# Centene Partners with National Council on Independent Living (NCIL)

- Barrier Removal Fund
  - provider accessibility initiative in Illinois, Texas, Ohio
- 52 health providers received grants for barrier removal and purchase of accessible equipment
- 2500 on-site accessibility site reviews conducted with the help of Centers for Independent Living
- More states planned in 2019
- Centene receives CMS Health Equity Awards

# Conclusion

- Progress at the federal level acknowledging physical and programmatic access barriers
- Health plans play an important role
- Ongoing problems include:
  - gaps in data collection
  - limited mechanisms for provider training and awareness
  - lack of a tested and validated uniform physical and programmatic access survey
  - no standards for including accommodation (programmatic access) needs in electronic health records

# Resources

Resources for Integrated Care, CMS MMCO

<https://www.resourcesforintegratedcare.com/concepts/disability-competent-care>)

*Core Competencies on Disability for Health Care Education*, Ohio State University and Alliance for Disability and Health Care Education

[http://nisonger.osu.edu/wp-content/uploads/2018/09/Core-Competencies-on-Disability-PPT\\_9.2018.pdf](http://nisonger.osu.edu/wp-content/uploads/2018/09/Core-Competencies-on-Disability-PPT_9.2018.pdf)

Promoting Physical and Programmatic Accessibility in Managed Long Term Services and Supports Programs

<https://clpc.ucsf.edu/publications/promoting-physical-and-programmatic-accessibility-managed-long-term-services-and>

Nancy R. Mudrick, M.S.W., Ph.D. & Silvia Yee, Esq., “Defining Programmatic Access to Healthcare or People with Disabilities,” Disability Rights Education and Defense Fund (DREDF), Berkeley, California, 2007, updated 2014

<https://dredf.org/wp-content/uploads/2012/08/Healthcarepgmaccess.pdf>

# References

Assuring Health Equity for Minority Persons with Disabilities: A Statement of Principles and Recommendations. (2011). Washington, D.C.: US Department of Health and Human Services Advisory Committee on Minority Health (ACMH), p. 7.

#Colton, C.W. and Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. [Preventing Chronic Disease.](#)

\*Courtney-Long, E., Armour, B., Frammartino, B., & Miller, J. (2011). Factors associated with self-reported mammography use for women with and women without a disability. *Journal of Women's Health*, 20:1279-1286.

^Iezzoni, L.I., Ngo, L.H., Li, D, Roetzheim, R.G., Drews, R.E., McCarthy, E.P. (2008). Treatment disparities for disabled Medicare beneficiaries with stage I non-small cell lung cancer. *Arch Phys Med Rehabil*; 89:595-601.

Mudrick, N.R., Breslin, M.L., and Yee, S. (2012). Physical accessibility in primary health care settings: results from California on-site reviews. *Disability & Health Journal*; 5(3):159-167.

Mudrick, N.R. & Yee, S. (2007, 2014). Defining programmatic access to healthcare for people with disabilities. Disability Rights Education and Defense Fund (DREDF). Berkeley, California.

Mudrick, N.R., Breslin, M.L., and Swager, L.C. (2018). Equal care: accessibility of health care settings for people with disabilities across two time periods. Presentation at the Society for Social Work and Research annual meeting, Washington, D.C.

Breslin, M.L. Promoting physical and programmatic accessibility in managed long term services and supports programs. (2017) Community Living Policy Center. University of California San Francisco, San Francisco, CA, and Brandeis University, Boston, MA.



Disability Rights Education & Defense Fund

Disability Rights Education and Defense Fund (DREDF)

Ed Roberts Campus

3075 Adeline Street, Suite 210

Berkeley, CA 94703

510.644.2555

tty/fax 510.841.8645

[www.dredf.org](http://www.dredf.org)

Follow us on Twitter @DREDF

On [facebook.com/DREDF.org](https://facebook.com/DREDF.org)

[www.DREDF.org](http://www.DREDF.org)